FOR OHF USE

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 8000978

Facility Name: St John Hospital LTC Unit

Address: 800 East Carpenter (Number) Springfield (City) 62769 (Zip Code)

County: Sangamon

Telephone Number: (217)544-6464 **Fax #** (217)535-3989

IDPA ID Number: 370661238001

Date of Initial License for Current Owners: 06/01/1977

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	USCC 928		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Dave Harms **Telephone Number:** (217)544-6464 ext 44395

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/1999 to 06/30/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Richard Carlson

(Title) Acting CEO

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number St John Hospital LTC Unit # 8000978 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	78	Skilled (SNF)	78	28,548	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	78	TOTALS	78	28,548	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	674	206	10,366	11,246	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	674	206	10,366	11,246	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 39.39%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Adult Day Care

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 06/01/1977

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 78 and days of care provided 7,231

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/2000 Fiscal Year: 06/30/2000

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number St John Hospital LTC Unit # 8000978 **Report Period Beginning:** 07/01/1999 **Ending:** 06/30/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary											1
2	Food Purchase											2
3	Housekeeping											3
4	Laundry											4
5	Heat and Other Utilities			109,053	109,053		109,053	(109,053)				5
6	Maintenance		2,588	11,137	13,725		13,725	(13,725)				6
7	Other (specify):*											7
8	**TOTAL General Services**		2,588	120,190	122,778		122,778	(122,778)				8
	B. Health Care and Programs											
9	Medical Director	31,099			31,099		31,099		31,099			9
10	Nursing and Medical Records	6,349,711	1,069,690	1,646,915	9,066,316		9,066,316	4,184,389	13,250,705			10
10a	Therapy	197,562	5,606	468	203,636		203,636	(203,636)				10a
11	Activities											11
12	Social Services											12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* Day Care	142,392	4,247	13,125	159,764		159,764	200,301	360,065			15
16	**TOTAL Health Care and Programs**	6,720,764	1,079,543	1,660,508	9,460,815		9,460,815	4,181,054	13,641,869			16
	C. General Administration											
17	Administrative											17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions											20
21	Clerical & General Office Expenses	654,346	5,648	261,331	921,325		921,325	(427,338)	493,987			21
22	Employee Benefits & Payroll Taxes											22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			1,174	1,174		1,174	(1,174)				26
27	Other (specify):*											27
28	**TOTAL General Administration**	654,346	5,648	262,505	922,499		922,499	(428,512)	493,987			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	7,375,110	1,087,779	2,043,203	10,506,092		10,506,092	3,629,764	14,135,856			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number St John Hospital LTC Unit #8000978 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			181,482	181,482		181,482	(134,550)	46,932			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			181,482	181,482		181,482	(134,550)	46,932			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			42,705	42,705		42,705		42,705			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			42,705	42,705		42,705		42,705			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,375,110	1,087,779	2,267,390	10,730,279		10,730,279	3,495,214	14,225,493			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number St John Hospital LTC Unit # 8000978 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$ 200,031	15	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(134,550)	30		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	3,429,463			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 3,494,944		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 3,494,944		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

St John Hospital LTC Unit

ID# 8000978

Report Period Beginning: 07/01/1999

Ending: 06/30/2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Heat & Utilities	$ (109,053)	5	1
2	Plant Operations	(13,725)	6	2
3	Nursing	4,184,389	10	3
4	Therapies	(203,636)	10a	4
5	General Office	(427,338)	21	5
6	Ins/Prof Malpractice	(1,174)	26	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	3,429,463		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St John Hospital LTC Unit # 8000978 **Report Period Beginning:** 07/01/1999 **Ending:** 06/30/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(109,053)	0	0	0	0	0	0	0	0	0	0	(109,053)	5
6	Maintenance	(13,725)	0	0	0	0	0	0	0	0	0	0	(13,725)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(122,778)	0	0	0	0	0	0	0	0	0	0	(122,778)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	4,184,389	0	0	0	0	0	0	0	0	0	0	4,184,389	10
10a	Therapy	(203,636)	0	0	0	0	0	0	0	0	0	0	(203,636)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	200,031	0	0	0	0	0	0	0	0	0	0	200,031	15
16	**TOTAL Health Care and Programs**	4,180,784	0	0	0	0	0	0	0	0	0	0	4,180,784	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(427,338)	0	0	0	0	0	0	0	0	0	0	(427,338)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(1,174)	0	0	0	0	0	0	0	0	0	0	(1,174)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(428,512)	0	0	0	0	0	0	0	0	0	0	(428,512)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	3,629,494	0	0	0	0	0	0	0	0	0	0	3,629,494	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St John Hospital LTC Unit # 8000978 **Report Period Beginning:** 07/01/1999 **Ending:** 06/30/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(134,550)	0	0	0	0	0	0	0	0	0	0	(134,550)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(134,550)	0	0	0	0	0	0	0	0	0	0	(134,550)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,494,944	0	0	0	0	0	0	0	0	0	0	3,494,944	45

Facility Name & ID Number St John Hospital LTC Unit # 8000978 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Hospital Sisters Health Systems	100%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number St John Hospital LTC Unit # 8000978 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	NOT APPLICABLE								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number St John Hospital LTC Unit # 8000978 Report Period Beginning: 07/01/1999 Ending: 6/30/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: St. John's Hospital
Street Address: 800 East Carpenter
City / State / Zip Code: Springfield, IL
Phone Number: (217) 544-6464
Fax Number: (217) 535-3989

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		Note: Certain shared costs are				$	$		$	1
2		allocated between the Acute facility								2
3		and the North facility based on a								3
4		step-down method in accordance								4
5		with Medicare regulations.								5
6										6
7		SEE MEDICARE COST REPORT								7
8		FYE 06/30/2000								8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number St John Hospital LTC Unit # 8000978 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	NOT APPLICABLE						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number St John Hospital LTC Unit # 8000978 **Report Period Beginning:** 07/01/1999 **Ending:** 06/30/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$	#VALUE!	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	#VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number St John Hospital LTC Unit # 8000978 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 72,321 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 5

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Building	50,108	1977	$ 220,304	1
2					2
3	TOTALS	50,108		$ 220,304	3

Facility Name & ID Number St John Hospital LTC Unit # 8000978 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	78		1977	1972	$ 1,038,543	$ 29,705	35	$ 29,705	$	$ 682,788	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Custom Cabinets			1981	15,713	786	20	786		14,994	9
10	Boiler and Installation			1983	17,097	857	20	857		14,597	10
11	Fire Suppresion System			1985	1,185	33	15	33		1,185	11
12	Electronic Air Cleaner			1986	3,206	214	15	214		2,995	12
13	Roofing			1989	62,235	2,595	10	2,595		62,235	13
14	Teleraceway			1989	3,070	77	10	77		3,070	14
15	Nurse's Call System			1991	8,388	559	15	559		5,169	15
16	Windows			1991	4,599	306	15	306		2,859	16
17	Carpeting-Lobby/2nd Floor			1991	2,227	222	10	222		2,010	17
18	Move PT-SNF to 5th Floor			1991	49,583	2,479	20	2,479		22,931	18
19	Armstrong vinyl Flooring			1992	20,249	2,025	10	2,025		17,887	19
20	Canopy/Kitchen Entrance			1992	1,121	75	15	75		637	20
21	Flooring/Carpeting-Business Office			1993	2,229	230	10	230		1,759	21
22	Ambulance Garage			1993	2,228	229	10	229		1,774	22
23	Remodel School of Dietetics/IS Training Rooms			1993	18,603	1,860	10	1,860		13,565	23
24	Security System			1993	2,874	359	8	359		2,843	24
25	Remove electrical outlets			1993	2,422	242	10	242		1,856	25
26	Permanent Fixtures-Break Room			1993	151,626	7,581	20	7,581		55,594	26
27	Temporary Relocation of Business Office			1993	994	99	10	99		751	27
28	Canopy/Floor-Smoking Area			1993	1,587	106	15	106		839	28
29	Window Replacement			1994	22,038	2,204	10	2,204		14,146	29
30	A/C Units			1994	13,833	924	15	924		5,621	30
31	Wiring (Additional Labor/Fees)			1994	7,313	504	20	504		3,376	31
32	Libertas space considerations			1994	10,482	1,048	10	1,048		6,812	32
33	Remodel 5th Floor			1994	41,558	2,077	20	2,077		13,156	33
34	Hospice Patient Rooms			1995	14,595	973	5	973		14,595	34
35	Hydraulic Jack for Elevators			1995	24,100	2,410	10	2,410		13,657	35
36	TOTAL (lines 4 thru 35)				$ 1,543,698	$ 60,779		$ 60,779	$	$ 983,701	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St John Hospital LTC Unit # 8000978 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Increase Sleeping Rooms			1995	2,775	277	10	277		1,639	9
10	Wellness Center			1995	31,635	1,582	20	1,582		9,360	10
11	Exhaust to 5th Floor			1995	1,850	185	10	185		987	11
12	Exhaust in Beauty Shop			1995	2,307	231	10	231		1,135	12
13	Carpeting-Libertas			1996	5,953	695	5	695		2,780	13
14	Remodel Libertas' Nursing Station			1996	1,066	107	10	107		419	14
15	Hospice Dept. Improvements			1996	32,331	1,617	20	1,617		6,333	15
16	Feed for Elevator # 1			1997	6,413	641	10	641		1,977	16
17	Screening for Roof Areas			1998	3,581	358	10	358		1,044	17
18	Remodel for Home Health move			1998	75,823	5,055	15	5,055		14,744	18
19	Voice/Data Cabling			1998	146,507	14,651	10	14,651		42,732	19
20	Air Conditioners			1998	8,036	1,607	5	1,607		3,884	20
21	Install new Elevators			1998	95,071	4,754	20	4,754		13,073	21
22	Install Backflow Preventer			1998	6,298	630	10	630		1,837	22
23	Install Liebert Unit			1998	1,370	137	10	137		400	23
24	Metasys Install			2000	24,882	1,521	15	1,521		1,521	24
25	Installation of Intercom			2000	938	48	12	48		48	25
26	Install Circuits 5N25			2000	1,849	15	10	15		15	26
27	Laminar Flow Hood/Installation			2000	19,474	1,190	15	1,190		1,190	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 468,160	$ 35,301		$ 35,301	$	$ 105,118	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St John Hospital LTC Unit # 8000978 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 925,032	$ 64,803	$ 64,803	$		$ 590,036	37
38	Current Year Purchases	47,144	9,318	9,318			9,318	38
39	Fully Depreciated Assets						(43,884)	39
40	Transfers						4,115	40
41	TOTALS	$ 972,176	$ 74,121	$ 74,121	$		$ 559,585	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 3,204,337	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 170,201	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 170,201	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,648,404	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NOT APPLICABLE
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
   If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ ____ Description: ____
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number St John Hospital LTC Unit # 8000978 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	1941 hrs	$ 37,054		$	$ 1,228	1,941	$ 38,282	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	1489 hrs	44,033			942	1,489	44,975	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$ 81,087		$	$ 2,170	3,430	$ 83,257	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number St John Hospital LTC Unit # 8000978 **Report Period Beginning:** 07/01/1999 **Ending:** 06/30/2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$ 4,451,470	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 12,548,000)		78,074,558	3
4	Supply Inventory (priced at)		5,092,233	4
5	Short-Term Investments			5
6	Prepaid Insurance		1,042,998	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Foundation		1,000,000	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$ 89,661,259	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		12,052,570	13
14	Buildings, at Historical Cost		219,683,979	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		127,920,045	16
17	Accumulated Depreciation (book methods)		(165,753,270)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		266,788,114	21
22	Other Long-Term Assets (specify):		4,102,412	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 464,793,850	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$	$ 554,455,109	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$ 8,339,695	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable		11,429,154	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Current iNstallment of Long-Term Debt		3,040,000	36
37	3rd party reimb Payables		6,760,213	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$ 29,569,062	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		104,422,976	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Self-Insurance		13,959,358	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 118,382,334	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$ 147,951,396	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 406,503,713	$ 406,503,713	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 406,503,713	$ 554,455,109	48

***(See instructions.)**

Facility Name & ID Number St John Hospital LTC Unit # 8000978 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 392,360,517	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 392,360,517	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	14,160,908	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 14,160,908	17
	B. Transfers (Itemize):		
18	**Investment Income**	5,105	18
19	**Temorarily Restricted**	(22,817)	19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (17,712)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 406,503,713	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number St John Hospital LTC Unit # 8000978 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 15,351,036	1
2	Discounts and Allowances for all Levels	(4,361,394)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,989,642	3
	B. Ancillary Revenue		
4	Day Care	246,812	4
5	Other Care for Outpatients		5
6	Therapy	917,909	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,164,721	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	23,356	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 23,356	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,177,719	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	122,778	31
32	Health Care	9,460,815	32
33	General Administration	922,499	33
	B. Capital Expense		
34	Ownership	181,482	34
	C. Ancillary Expense		
35	Special Cost Centers	42,705	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,730,279	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,447,440	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,447,440	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number St John Hospital LTC Unit # 8000978 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing	14,077	16,496	513,599	31.13	2
3	Registered Nurses	145,352	169,173	3,616,150	21.38	3
4	Licensed Practical Nurses	19,309	23,100	321,603	13.92	4
5	Nurse Aides & Orderlies	60,742	71,089	687,829	9.68	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	14,645	16,622	458,043	27.56	7
8	Rehab/Therapy Aides	5,432	6,466	103,739	16.04	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	6,200	7,070	139,948	19.79	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers					18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	29,490	35,167	714,328	20.31	22
23	Office Manager	2,593	3,144	71,265	22.67	23
24	Clerical	43,886	51,175	537,086	10.50	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	445	445	31,099	69.89	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)	13,370	14,836	180,420	12.16	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	355,541	414,783	$ 7,375,109 *	$ 17.78	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number St John Hospital LTC Unit # 8000978 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
NOT APPLICABLE			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
NOT APPLICABLE	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
NOT APPLICABLE		$
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
H&W are shared costs	
allocated from the hospital	
using the step-down method	
on the Medicare Cost Report.	
TOTAL (agree to Schedule V, line 22, col.8)	$

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
NOT APPLICABLE		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
NOT APPLICABLE	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
NOT APPLICABLE	
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

Facility Name & ID Number St John Hospital LTC Unit # 8000978 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	NOT APPLICABLE		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number St John Hospital LTC Unit **#** 8000978 **Report Period Beginning:** 07/01/1999 **Ending:** 06/30/2000

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **15 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **42,705**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.